| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365195 | A. Building<br>B. Wing | 07/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McNaughten Pointe Nursing and Rehab | 1425 Yorkland Road<br>Columbus, OH 43232 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the American Nurse's Association standards of professional nursing practice, the facility failed to ensure specified parameters were obtained and recorded during medication administration. This affected one resident (#121) of four residents reviewed for medication administration. The facility census was 117.Findings include: Review of the closed medical record for Resident #121 revealed an admission date of 04/22/25 and discharge date of 05/15/25. Diagnoses included but were not limited to Tracheostomy, chronic respiratory status, dependence on ventilator, dysphagia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, gastrostomy, epilepsy, pleural effusions, vascular dementia, Down Syndrome, end stage renal disease, dependence on renal dialysis, and depression.Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not able to be completed because Resident #121 did not respond or verbally communicate. Staff reported the resident had both short-term and long-term memory problems. Resident #121 received antidepressant and anticonvulsant medications with indications documented. Resident #121 received oxygen therapy, suctioning, tracheostomy care, invasive mechanical ventilation, dialysis, and had IV access.Review of Resident #121's physician's orders revealed an order dated 05/01/25 for Midodrine (a medication used to raise blood pressure) 5 milligrams (mg), give one tablet via the percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted into the stomach to allow for enteral feedings and medication administration) three times daily for hypotension. Additional instructions included to hold the medication for a systolic blood pressure of greater than 120 millimeters of mercury (mmHg).Review of Resident #121's Medication Administration Record (MAR) for May 2025 revealed multiple doses of Midodrine were administered with no blood pressure readings documented at the corresponding times in the vital signs tab or in the nursing progress notes to indicate the blood pressure readings were within permitted range at the time of administration.Interview on 07/23 25 at 2:25 P.M. with Registered Nurse (RN) #548 revealed all vital signs tied to medication administration are obtained by the nurse at the time of medication administration. Routine vital signs are obtained by the Certified Nursing Assistants (CNA). The CNAs give the nurses the vital signs, and they are documented by the nurse. Vital signs are documented under the vital signs tab or in the progress notes.Interview on 07/23/25 at 2:32 P.M. with RN #503 revealed routine vital signs are completed by the CNAs. Vital signs that need checked to see if it is safe to give medication are done when the medication is due. All vital signs are documented in the vital signs tab by the nurses.Interview on 07/24/25 at 7:45 A.M. with CNA #462 revealed CNAs obtain the residents' vital signs and give them to the nurses to chart.Interview on 07/24/25 at 7:55 A.M. with RN #415 revealed routine vital signs are completed by the CNAs. Vital signs that need checked to see if it is safe to give medication are done when the medication is due. RN #415 reported all vital signs are documented in the vital sign tab by the nurses. Interview on 07/24/25 at 10:53 A.M. with the Director of Nursing (DON) revealed the expectation is the nurses sees that vital signs are obtained prior to medication administration with parameters, and then the nurse documents the vital signs either in a progress note or on the vital signs tab within the electronic medical record. The DON stated the nurses are taught that the expectation is to document the vital signs if the medication needs to be held. When the nurses are administering medications and they decide to withhold a medication, they select a corresponding chart code to indicate why the medication was held. The DON reported there is no trigger to document if the vital sign is within parameters. A policy for medication administration was requested on 07/23/25 and 07/24/25 and was not received during the survey.Review of the American Nurses Association standards of Professional Nursing Practice revealed all professional nurses should maintain accurate and timely documentation of patient care, including assessments, interventions, and outcomes. |